

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010772
STATE FILE NUMBER

Registration District No. 3 No. 3058

FILED APR 10 1959

Registration District No.

Primary Registration District No.

Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Louis</u> TOWN		c. CITY OR TOWN <u>Murphysboro</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. STILL BORN IN (If not, give birth location) HOSPITAL OR <u>Hospitals, Inc.</u> INSTITUTION		d. STREET ADDRESS <u>2222 Pine Street</u>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Monroe</u> Last <u>Burnett</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> , Year <u>1959</u>	
5. SEX <u>Male</u> 0	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1889</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>69</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossing Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Paragould, Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Jefferson David Burnett</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Edna Burnett</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>702-12-6595</u>	17. INFORMANT <u>Lottie Marshall</u> Address <u>Murphysboro, Illinois</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Urinary Bladder</u> Conditions, if any, which gave rise to above cause (b) <u>Pathological Fracture Right Femur</u> Long cause lost. DUE TO (c) <u>Pulmonary Metastases</u> 8/26/59			INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>3-15-59</u> <u>181.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>8/26/59</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT / SUICIDE / HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>At Home - 3-15-59 - Getting out of Bed - Did not fall -</u>	
20c. TIME OF INJURY Hour <u>?</u> a.m. <u>3-15-59</u> p.m. <u>?</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>AT HOME</u>		20f. CITY, TOWN, OR LOCATION <u>Murphysboro</u>	
20g. COUNTY <u>Ill</u>		20h. STATE <u>Ill</u>	
21. I attended the deceased from <u>Mar. 16-59</u> to <u>March 26, 1959</u> and last saw him alive on <u>March 25, 1959</u> Death occurred at <u>2:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph A. Lembeck, M.D.</u>		22b. ADDRESS <u>1755 South Grand Ave</u>	22c. DATE SIGNED <u>3-26-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Meyer-Denny Funeral Home Murphysboro, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar 26 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Color, tubular, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Not Embalmed....., Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

John J. Kasey III

Licensed Embalmer No. 1199

P. O. Address Hellerville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

• If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.